

**STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
WORKERS' COMPENSATION APPEALS BOARD**

V.	APPLICANT
DEFENDANT(S).	

CASE NO. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRE-TRIAL CONFERENCE STATEMENT §5502 (d) (3)  
☐ NOTICE OF HEARING

LOCATION: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

SETTLEMENT CONFERENCE JUDGE: \_\_\_\_\_

**APPEARANCES:**

☐ INJURED WORKER: \_\_\_\_\_

☐ INJURED WORKER'S ATTORNEY \_\_\_\_\_

☐ ATTY ☐ HRG REP

\_\_\_\_\_  
(FIRM NAME AND PERSON APPEARING)

☐ DEFENDANT'S ATTORNEY \_\_\_\_\_

☐ ATTY ☐ HRG REP

☐ ATTY ☐ HRG REP

☐ ATTY ☐ HRG REP

☐ ATTY ☐ HRG REP

\_\_\_\_\_  
(FIRM NAME AND PERSON APPEARING)

\_\_\_\_\_  
(DEFENDANT)

☐ OTHERS APPEARING:  
(L.C., INTERPRETERS, ETC.) \_\_\_\_\_

☐ ADDRESS RECORD CHANGES: \_\_\_\_\_  
\_\_\_\_\_

**BOX BELOW TO BE COMPLETED ONLY BY WORKERS' COMPENSATION JUDGE**

**DISPOSITION: SET FOR REGULAR HEARING:**

☐ WCAB NOTICE ☐ NOTICE WAIVED

☐ 1 HOUR ☐ 2 HOURS ☐ 1/2 DAY ☐ ALL DAY

☐ BEFORE ANY WCJ ☐ BEFORE WCJ \_\_\_\_\_ ☐ BEFORE ANY WCJ OTHER THAN \_\_\_\_\_

☐ CASE(S) SET ON \_\_\_\_\_ AT \_\_\_\_\_ WCJ \_\_\_\_\_ IN \_\_\_\_\_  
(DATE) (TIME) (LOCATION)

☐ **OTHER DISPOSITION AND ORDERS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SERVICE AS ORDERED ON PAGE 4

\_\_\_\_\_  
**WORKERS' COMPENSATION  
ADMINISTRATIVE LAW JUDGE**

## STIPULATIONS

## THE FOLLOWING FACTS ARE ADMITTED:

1. \_\_\_\_\_, BORN \_\_\_\_/\_\_\_\_/\_\_\_\_

WHILE ☐ EMPLOYED ☐ ALLEGEDLY EMPLOYED

☐ ON \_\_\_\_\_

☐ DURING THE PERIOD(S) \_\_\_\_\_

AS A(N) \_\_\_\_\_, OCCUPATIONAL GROUP NUMBER \_\_\_\_\_

AT \_\_\_\_\_, CALIFORNIA,

BY \_\_\_\_\_

☐ SUSTAINED INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT TO \_\_\_\_\_

☐ CLAIMS TO HAVE SUSTAINED INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT TO \_\_\_\_\_

2. AT THE TIME OF INJURY THE EMPLOYER'S WORKERS' COMPENSATION CARRIER WAS \_\_\_\_\_

☐ THE EMPLOYER WAS ☐ PERMISSIBLY SELF-INSURED ☐ UNINSURED ☐ LEGALLY UNINSURED

3. AT THE TIME OF INJURY, THE EMPLOYEE'S EARNINGS WERE \$ \_\_\_\_\_ PER WEEK, WARRANTING INDEMNITY RATES OF \$ \_\_\_\_\_ FOR TEMPORARY DISABILITY AND \$ \_\_\_\_\_ FOR PERMANENT DISABILITY.

4. THE CARRIER/EMPLOYER HAS PAID COMPENSATION AS FOLLOWS: (TD/PD/VRMA)

TYPE	WEEKLY RATE	PERIOD	TYPE	WEEKLY RATE	PERIOD
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

☐ THE EMPLOYEE HAS BEEN ADEQUATELY COMPENSATED FOR ALL PERIODS OF T/D CLAIMED THROUGH \_\_\_\_\_

5. THE EMPLOYER HAS FURNISHED ☐ ALL ☐ SOME ☐ NO MEDICAL TREATMENT.

THE PRIMARY TREATING PHYSICIAN IS \_\_\_\_\_

6. ☐ NO ATTORNEY FEES HAVE BEEN PAID AND NO ATTORNEY FEE ARRANGEMENTS HAVE BEEN MADE.

7. ☐ OTHER STIPULATIONS \_\_\_\_\_

\_\_\_\_\_  
APPLICANT

\_\_\_\_\_  
DEFENDANT

\_\_\_\_\_  
LIEN CLAIMANT/OTHER

**PRE-TRIAL CONFERENCE STATEMENT**

**CASE NO.** \_\_\_\_\_

**ISSUES**

- ☐ EMPLOYMENT \_\_\_\_\_
- ☐ INSURANCE COVERAGE \_\_\_\_\_
- ☐ INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT \_\_\_\_\_
- ☐ PARTS OF BODY INJURED: \_\_\_\_\_
- ☐ EARNINGS: EMPLOYEE CLAIMS \_\_\_\_\_ PER WEEK, BASED ON \_\_\_\_\_  
 EMPLOYER/CARRIER CLAIMS \_\_\_\_\_ PER WEEK, BASED ON \_\_\_\_\_
- ☐ TEMPORARY DISABILITY, EMPLOYEE CLAIMING THE FOLLOWING PERIOD(S): \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- ☐ PERMANENT AND STATIONARY DATE:  
 EMPLOYEE CLAIMS \_\_\_\_/\_\_\_\_/\_\_\_\_, BASED ON \_\_\_\_\_  
 EMPLOYER/CARRIER CLAIMS \_\_\_\_/\_\_\_\_/\_\_\_\_, BASED ON \_\_\_\_\_
- ☐ PERMANENT DISABILITY    ☐ APPORTIONMENT
- ☐ OCCUPATION AND GROUP NUMBER CLAIMED: BY EMPLOYEE \_\_\_\_\_  
 BY EMPLOYER/CARRIER \_\_\_\_\_
- ☐ NEED FOR FURTHER MEDICAL TREATMENT \_\_\_\_\_
- ☐ LIABILITY FOR SELF-PROCURED MEDICAL TREATMENT \_\_\_\_\_
- \_\_\_\_\_

☐ LIENS:

<u>LIEN CLAIMANT</u>	<u>TYPE OF LIEN</u>	<u>AMOUNT AND PERIODS PAID</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- ☐ ATTORNEY FEES
- ☐ OTHER ISSUES: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_  
 APPLICANT

\_\_\_\_\_  
 DEFENDANT

\_\_\_\_\_  
 LIEN CLAIMANT/OTHER

**PRE-TRIAL CONFERENCE STATEMENT**

**CASE NO.** \_\_\_\_\_

**THIS PAGE FOR JUDGE'S USE ONLY**

**JUDGE'S CONFERENCE NOTES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ORDERS**

☐ **IT IS ORDERED** PURSUANT TO WCAB RULE 10500, THAT ☐ DEFENDANT ☐ APPLICANT ☐ LIEN CLAIMANT SERVE FORTHWITH THIS ☐ PRE-TRIAL CONFERENCE STATEMENT ☐ NOTICE OF HEARING ON ALL PARTIES OR THEIR REPRESENTATIVE SHOWN ON THE OFFICIAL ADDRESS RECORD AND ANY ADDITIONAL LIEN CLAIMANTS WHOSE LIENS ARE SHOWN UNDER **ISSUES** (PAGE 3).

☐ **IT IS FURTHER ORDERED** THAT ☐ DEFENDANT ☐ APPLICANT ☐ LIEN CLAIMANT SERVE TIMELY NOTICE OF THE TIME AND PLACE OF ALL REGULAR HEARING SESSIONS ON ALL LIEN CLAIMANTS WHOSE LIENS ARE SHOWN UNDER ISSUES, TOGETHER WITH THE FOLLOWING NOTICE: **YOUR LIEN IS AT ISSUE AND WILL BE ADJUDICATED AT REGULAR HEARING.**

**IT IS FURTHER ORDERED** THAT THE PROOF OF SERVICE ORDERED ABOVE BE FILED WITH THE WCAB **ONLY** ON REQUEST OF THE ASSIGNED WORKERS' COMPENSATION JUDGE.

OTHER DISPOSITION AND ORDERS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SERVICE OF THIS DOCUMENT WAS MADE PERSONALLY UPON \_\_\_\_\_ BY WCJ.

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

**WORKERS' COMPENSATION  
ADMINISTRATIVE LAW JUDGE**

**CASE NO.** \_\_\_\_\_

☐ APPLICANT  
☐ DEFENDANT  
☐ LIEN CLAIMANT  
☐ APPEALS BOARD

DATE \_\_\_\_\_

[illegible]


LIEN CLAIMANT/OTHER

1. APPLICANT, BORN \_\_\_\_\_, SUSTAINED OR CLAIMS INJURY AS FOLLOWS:

	(1)	(2)	(3)	(4)
CASE NO.				
DOI				
	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>	CLAIMS <input type="checkbox"/> ADMITTED <input type="checkbox"/>
BODY PARTS				
JOB TITLE(S) OCCUPATIONAL GROUP NO(S).				
EARNINGS & TD/PD RATES				
EMPLOYER				
CARRIER ADJUSTED BY				
WORK COMP SECURED BY	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>	INSURED <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/>
COVERAGE DATES				

2. THE CARRIER/EMPLOYER HAS PAID COMPENSATION AS FOLLOWS:

<u>TYPE</u>	<u>WEEKLY RATE</u>	<u>PERIOD</u>	<u>PAID BY</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. ☐ THE EMPLOYEE HAS BEEN ADEQUATELY COMPENSATED FOR ALL PERIODS OF TEMPORARY DISABILITY CLAIMED THROUGH \_\_\_\_\_.

4. THE EMPLOYER HAS FURNISHED ☐ ALL ☐ SOME ☐ NO MEDICAL TREATMENT.  
THE PRIMARY TREATING PHYSICIAN IS \_\_\_\_\_.

5. ☐ NO ATTORNEY FEES HAVE BEEN PAID AND NO ATTORNEY FEE AGREEMENTS HAVE BEEN MADE.

6. ☐ OTHER STIPULATIONS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_